4.4: Diagnosis

**Diagnosis** is the second step of the nursing process (and the second Standard of Practice set by the American Nurses Association). This standard is defined as, “The registered nurse analyzes assessment data to determine actual or potential diagnoses, problems, and issues.” The RN “prioritizes diagnoses, problems, and issues based on mutually established goals to meet the needs of the health care consumer across the health–illness continuum and the care continuum.” Diagnoses, problems, strengths, and issues are documented in a manner that facilitates the development of expected outcomes and a collaborative plan. [1]

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**Analyzing Assessment Data**

After collection of assessment data, the registered nurse analyzes the data to form generalizations and create hypotheses for nursing diagnoses. Steps for analyzing assessment data include performing data analysis, clustering of information, identifying hypotheses for potential nursing diagnosis, performing additional in-depth assessment as needed, and establishing nursing diagnosis statements. The nursing diagnoses are then prioritized and drive the nursing care plan. [2]

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**Performing Data Analysis**

After nurses collect assessment data from a patient, they use their nursing knowledge to analyze that data to determine if it is “expected” or “unexpected” or “normal” or “abnormal” for that patient according to their age, development, and baseline status. From there, nurses determine what data are “clinically relevant” as they prioritize their nursing care. [3]

**Example.** In Scenario C in the “Assessment” section of this chapter, the nurse analyzes the vital signs data and
determines the blood pressure, heart rate, and respiratory rate are elevated, and the oxygen saturation is decreased for this patient. These findings are considered “relevant cues.”

**Clustering Information/Seeing Patterns/Making Hypotheses**

After analyzing the data and determining relevant cues, the nurse clusters data into patterns. Assessment frameworks such as Gordon’s Functional Health Patterns assist nurses in clustering information according to evidence-based patterns of human responses. See the box below for an outline of Gordon’s Functional Health Patterns. Concepts related to many of these patterns will be discussed in chapters later in this book.

**Example.** Refer to Scenario C of the “Assessment” section of this chapter. The nurse clusters the following relevant cues: elevated blood pressure, elevated respiratory rate, crackles in the lungs, weight gain, worsening edema, shortness of breath, a medical history of heart failure, and currently prescribed a diuretic medication. These cues are clustered into a generalization/pattern of fluid balance, which can be classified under Gordon’s Nutritional-Metabolic Functional Health Pattern. The nurse makes a hypothesis that the patient has excess fluid volume present.

**Gordon’s Functional Health Patterns**

- **Health Perception-Health Management:** A patient’s perception of their health and well-being and how it is managed
- **Nutritional-Metabolic:** Food and fluid consumption relative to metabolic need
- **Elimination:** Excretory function, including bowel, bladder, and skin
- **Activity-Exercise:** Exercise and daily activities
- **Sleep-Rest:** Sleep, rest, and daily activities
- **Cognitive-Perceptual:** Perception and cognition
- **Self-perception and Self-concept:** Self-concept and perception of self-worth, self-competency, body image, and mood state
- **Role-Relationship:** Role engagements and relationships
- **Sexuality-Reproductive:** Reproduction and satisfaction or dissatisfaction with sexuality
- **Coping-Stress Tolerance:** Coping and effectiveness in terms of stress tolerance
- **Value-Belief:** Values, beliefs (including spiritual beliefs), and goals that guide choices and decisions

**Identifying Nursing Diagnoses**

After the nurse has analyzed and clustered the data from the patient assessment, the next step is to begin to answer the
question, “What are my patient’s human responses (i.e., nursing diagnoses)?” A **nursing diagnosis** is defined as, “A clinical judgment concerning a human response to health conditions/life processes, or a vulnerability for that response, by an individual, family, group, or community.” Nursing diagnoses are customized to each patient and drive the development of the nursing care plan. The nurse should refer to a care planning resource and review the definitions and defining characteristics of the hypothesized nursing diagnoses to determine if additional in-depth assessment is needed before selecting the most accurate nursing diagnosis.

Nursing diagnoses are developed by nurses, for use by nurses. For example, NANDA International (NANDA-I) is a global professional nursing organization that develops nursing terminology that names actual or potential human responses to health problems and life processes based on research findings. Currently, there are over 220 NANDA-I nursing diagnoses developed by nurses around the world. This list is continuously updated, with new nursing diagnoses added and old nursing diagnoses retired that no longer have supporting evidence. A list of commonly used NANDA-I diagnoses are listed in Appendix A. For a full list of NANDA-I nursing diagnoses, refer to a current nursing care plan reference.

NANDA-I nursing diagnoses are grouped into 13 domains that assist the nurse in selecting diagnoses based on the patterns of clustered data. These domains are similar to Gordon’s Functional Health Patterns and include health promotion, nutrition, elimination and exchange, activity/rest, perception/cognition, self-perception, role relationship, sexuality, coping/stress tolerance, life principles, safety/protection, comfort, and growth/development.

**Note**

Knowledge regarding specific NANDA-I nursing diagnoses is not assessed on the NCLEX. However, analyzing cues and creating hypotheses are part of the measurement model used to assess a candidate’s clinical judgment. Read more about the NCLEX and Next Generation NCLEX in the “Scope of Practice” chapter.

### Nursing Diagnoses vs. Medical Diagnoses

You may be asking yourself, “How are nursing diagnoses different from medical diagnoses?” Medical diagnoses focus on diseases or other medical problems that have been identified by the physician, physician’s assistant, or advanced nurse practitioner. Nursing diagnoses focus on the **human response** to health conditions and life processes and are made independently by RNs. Patients with the same medical diagnosis will often **respond** differently to that diagnosis and thus have different nursing diagnoses. For example, two patients have the same medical diagnosis of heart failure. However, one patient may be interested in learning more information about the condition and the medications used to treat it, whereas another patient may be experiencing anxiety when thinking about the effects this medical diagnosis will have on their family. The nurse must consider these different responses when creating the nursing care plan. Nursing diagnoses consider the patient’s and family’s needs, attitudes, strengths, challenges, and resources as a customized nursing care plan is created to provide holistic and individualized care for each patient.

**Example.** A medical diagnosis identified for Ms. J. in Scenario C in the “Assessment” section is heart failure. This cannot be used as a nursing diagnosis, but it can be considered as an “associated condition” when creating hypotheses for nursing diagnoses. Associated conditions are medical diagnoses, injuries, procedures, medical devices, or pharmacological agents that are not independently modifiable by the nurse, but support accuracy in nursing diagnosis.
The nursing diagnosis in Scenario C will be related to the patient’s response to heart failure.

Additional Definitions Used in NANDA-I Nursing Diagnoses

The following definitions of patient, age, and time are used in association with NANDA-I nursing diagnoses:

Patient

The NANDA-I definition of a "patient" includes:

- **Individual**: a single human being distinct from others (i.e., a person).
- **Caregiver**: a family member or helper who regularly looks after a child or a sick, elderly, or disabled person.
- **Family**: two or more people having continuous or sustained relationships, perceiving reciprocal obligations, sensing common meaning, and sharing certain obligations toward others; related by blood and/or choice.
- **Group**: a number of people with shared characteristics generally referred to as an ethnic group.
- **Community**: a group of people living in the same locale under the same governance. Examples include neighborhoods and cities.

Age

The age of the person who is the subject of the diagnosis is defined by the following terms:

- **Fetus**: an unborn human more than eight weeks after conception, until birth.
- **Neonate**: a person less than 28 days of age.
- **Infant**: a person greater than 28 days and less than 1 year of age.
- **Child**: a person aged 1 to 9 years
- **Adolescent**: a person aged 10 to 19 years
- **Adult**: a person older than 19 years of age unless national law defines a person as being an adult at an earlier age.
- **Older adult**: a person greater than 65 years of age.

Time

The duration of the diagnosis is defined by the following terms:

- **Acute**: lasting less than 3 months.
- **Chronic**: lasting greater than 3 months.
- **Intermittent**: stopping or starting again at intervals
- **Continuous**: uninterrupted, going on without stop.

New Terms Used in 2018-2020 NANDA-I Diagnoses

The 2018-2020 edition of Nursing Diagnoses includes two new terms to assist in creating nursing diagnoses: at-risk
populations and associated conditions. [11]

**At-Risk Populations** are groups of people who share a characteristic that causes each member to be susceptible to a particular human response, such as demographics, health/family history, stages of growth/development, or exposure to certain events/experiences.

**Associated Conditions** are medical diagnoses, injuries, procedures, medical devices, or pharmacological agents. These conditions are not independently modifiable by the nurse, but support accuracy in nursing diagnosis [12]

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### Types of Nursing Diagnoses

There are four types of NANDA-I nursing diagnoses: [13]

- Problem-Focused
- Health Promotion – Wellness
- Risk
- Syndrome

A **problem-focused nursing diagnosis** is a “clinical judgment concerning an undesirable human response to health condition/life processes that exist in an individual, family, group, or community.” [14] To make an accurate problem-focused diagnosis, related factors and defining characteristics must be present. **Related factors** (also called etiology) are causes that contribute to the diagnosis. **Defining characteristics** are cues, signs, and symptoms that cluster into patterns. [15]

A **health promotion-wellness nursing diagnosis** is "a clinical judgment concerning motivation and desire to increase well-being and to actualize human health potential." These responses are expressed by the patient’s readiness to enhance specific health behaviors. [16] A health promotion-wellness diagnosis is used when the patient is willing to improve a lack of knowledge, coping, or other identified need.

A **risk nursing diagnosis** is "a clinical judgment concerning the vulnerability of an individual, family, group, or community for developing an undesirable human response to health conditions/life processes." [17] A risk nursing diagnosis must be supported by risk factors that contribute to the increased vulnerability. A risk nursing diagnosis is different from the problem-focused diagnosis in that the problem has not yet actually occurred. Problem diagnoses should not be automatically viewed as more important than risk diagnoses because sometimes a risk diagnosis can have the highest priority for a patient. [18]

A **syndrome diagnosis** is a “clinical judgment concerning a specific cluster of nursing diagnoses that occur together, and are best addressed together and through similar interventions.” [19]

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Establishing Nursing Diagnosis Statements

When using NANDA-I nursing diagnoses, NANDA-I recommends the structure of a nursing diagnosis should be a statement that includes the nursing diagnosis and related factors as exhibited by defining characteristics. The accuracy of the nursing diagnosis is validated when a nurse is able to clearly link the defining characteristics, related factors, and/or risk factors found during the patient’s assessment. 

To create a nursing diagnosis statement, the registered nurse completes the following steps. After analyzing the patient’s subjective and objective data and clustering the data into patterns, the nurse generates hypotheses for nursing diagnoses based on how the patterns meet defining characteristics of a nursing diagnosis. Defining characteristics is the terminology used for observable signs and symptoms related to a nursing diagnosis. Defining characteristics are included in care planning resources for each nursing diagnosis, along with a definition of that diagnosis, so the nurse can select the most accurate diagnosis. For example, objective and subjective data such as weight, height, and dietary intake can be clustered together as defining characteristics for the nursing diagnosis of nutritional status.

When creating a nursing diagnosis statement, the nurse also identifies the cause of the problem for that specific patient. Related factors is the terminology used for the underlying causes (etiology) of a patient’s problem or situation. Related factors should not be a medical diagnosis, but instead should be attributed to the underlying pathophysiology that the nurse can treat. When possible, the nursing interventions planned for each nursing diagnosis should attempt to modify or remove these related factors that are the underlying cause of the nursing diagnosis.

Creating nursing diagnosis statements has traditionally been referred to as “using PES format.” The PES mnemonic no longer applies to the current terminology used by NANDA-I, but the components of a nursing diagnosis statement remain the same. A nursing diagnosis statement should contain the problem, related factors, and defining characteristics. These terms fit under the former PES format in this manner:

Problem (P) – the patient problem (i.e., the nursing diagnosis)

Etiology (E) – related factors (i.e., the etiology/cause) of the nursing diagnosis; phrased as “related to” or “R/T”

Signs and Symptoms (S) – defining characteristics manifested by the patient (i.e., the signs and symptoms/subjective and objective data) that led to the identification of that nursing diagnosis for the patient; phrased with “as manifested by” or “as evidenced by.”

Examples of different types of nursing diagnoses are further explained below.

Problem-Focused Nursing Diagnosis

A problem-focused nursing diagnosis contains all three components of the PES format:

Problem (P) – statement of the patient response (nursing diagnosis)

Etiology (E) – related factors contributing to the nursing diagnosis
Signs and Symptoms (S) – defining characteristics manifested by that patient

Sample Problem-Focused Nursing Diagnosis Statement

Refer to Scenario C of the “Assessment” section of this chapter. The cluster of data for Ms. J. (elevated blood pressure, elevated respiratory rate, crackles in the lungs, weight gain, worsening edema, and shortness of breath) are defining characteristics for the NANDA-I Nursing Diagnosis Excess Fluid Volume. The NANDA-I definition of Excess Fluid Volume is “surplus intake and/or retention of fluid.” The related factor (etiology) of the problem is that the patient has excessive fluid intake.

Example

The components of a problem-focused nursing diagnosis statement for Ms. J. would be:

(P) Fluid Volume Excess

(E) Related to excessive fluid intake

(S) As manifested by bilateral basilar crackles in the lungs, bilateral 2+ pitting edema of the ankles and feet, increased weight of 10 pounds, and the patient reports, “My ankles are so swollen.”

A correctly written problem-focused nursing diagnosis statement for Ms. J. would look like this:

Fluid Volume Excess related to excessive fluid intake as manifested by bilateral basilar crackles in the lungs, bilateral 2+ pitting edema of the ankles and feet, an increase weight of 10 pounds, and the patient reports, “My ankles are so swollen.”

Health-Promotion Nursing Diagnosis

A health-promotion nursing diagnosis statement contains the problem (P) and the defining characteristics (S). The defining characteristics component of a health-promotion nursing diagnosis statement should begin with the phrase “expresses desire to enhance”.

Problem (P) – statement of the patient response (nursing diagnosis)

Signs and Symptoms (S) – the patient’s expressed desire to enhance

Sample Health-Promotion Nursing Diagnosis Statement

Refer to Scenario C in the “Assessment” section of this chapter. Ms. J. demonstrates a readiness to improve her health status when she told the nurse that she would like to “learn more about my health so I can take better care of myself.” This statement is a defining characteristic of the NANDA-I nursing diagnosis Readiness for Enhanced Health Management, which is defined as “a pattern of regulating and integrating into daily living a therapeutic regimen for the treatment of illness and its sequelae, which can be strengthened.”
The components of a health-promotion nursing diagnosis for Ms. J. would be:

**Problem (P):** Readiness for Enhanced Health Management

**Symptoms (S):** Expressed desire to “learn more about my health so I can take better care of myself.”

A correctly written health-promotion nursing diagnosis statement for Ms. J. would look like this:

*Enhanced Readiness for Health Promotion as manifested by expressed desire to “learn more about my health so I can take better care of myself.”*

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### Risk Nursing Diagnosis

A risk nursing diagnosis should be supported by evidence of the patient’s risk factors for developing that problem. Different experts recommend different phrasing. NANDA-I 2018-2020 recommends using the phrase “as evidenced by” to refer to the risk factors for developing that problem.[26]

A risk diagnosis consists of the following:

**Problem (P)** – statement of the patient response (nursing diagnosis)

**As Evidenced By** – Risk factors for developing the problem

### Sample Risk Diagnosis Statement

Refer to Scenario C in the “Assessment” section of this chapter. Ms. J. has an increased risk of falling due to vulnerability from the dizziness and weakness she is experiencing. The NANDA-I definition of Risk for Falls is “increased susceptibility to falling, which may cause physical harm and compromise health.”[27]

**Example**

The components of a risk diagnosis statement for Ms. J. would be:

**Problem (P)** – Risk for Falls

**As Evidenced By** – Dizziness and decreased lower extremity strength

A correctly written risk nursing diagnosis statement for Ms. J. would look like this:

*Risk for Falls as evidenced by dizziness and decreased lower extremity strength.*

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### Syndrome Diagnosis

A syndrome is a cluster of nursing diagnoses that occur together and are best addressed together and through similar interventions. To create a syndrome diagnosis, two or more nursing diagnoses must be used as defining characteristics (S) that create a syndrome. Related factors may be used if they add clarity to the definition, but are not required.[28]
A syndrome statement consists of these items:

**Problem (P)** – the syndrome

**Signs and Symptoms (S)** – the defining characteristics are two or more similar nursing diagnoses

**Sample Syndrome Diagnosis Statement**

Refer to Scenario C in the "Assessment" section of this chapter. Clustering the data for Ms. J. identifies several similar NANDA-I nursing diagnoses that can be categorized as a syndrome. For example, *Activity Intolerance* is defined as "insufficient physiological or psychological energy to endure or complete required or desired daily activities." *Social Isolation* is defined as "aloneness experienced by the individual and perceived as imposed by others and as a negative or threatening state." These diagnoses can be included under the NANDA-I syndrome named *Risk for Frail Elderly Syndrome*. This syndrome is defined as a "dynamic state of unstable equilibrium that affects the older individual experiencing deterioration in one or more domains of health (physical, functional, psychological, or social) and leads to increased susceptibility to adverse health effects, in particular disability."[29]

**Example**

The components of a syndrome nursing diagnosis for Ms. J. would be:

**(P)** – Risk for Frail Elderly Syndrome

**(S)** – The nursing diagnoses of *Activity Intolerance* and *Social Isolation*

**Additional related factor:** Fear of falling

A correctly written syndrome diagnosis statement for Ms. J. would look like this:

*Risk for Frail Elderly Syndrome related to activity intolerance, social isolation, and fear of falling*

**Prioritization**

After identifying nursing diagnoses, the next step is prioritization according to the specific needs of the patient. Nurses prioritize their actions while providing patient care multiple times every day. Prioritization is the process that identifies the most significant nursing problems, as well as the most important interventions, in the nursing care plan.

It is essential that life-threatening concerns and crises are identified immediately and addressed quickly. Depending on the severity of a problem, the steps of the nursing process may be performed in a matter of seconds for life-threatening concerns. In critical situations, the steps of the nursing process are performed through rapid clinical judgment. Nurses must recognize cues signaling a change in patient condition, apply evidence-based practices in a crisis, and communicate effectively with interprofessional team members. Most patient situations fall somewhere between a crisis and routine care.

There are several concepts used to prioritize, including Maslow’s Hierarchy of Needs, the “ABCs” (Airway, Breathing
and Circulation), and acute, uncompensated conditions. See the infographic in Figure 4.7 on The How To of Prioritization.

Figure 4.7 The How To of Prioritization

Maslow’s Hierarchy of Needs is used to categorize the most urgent patient needs. The bottom levels of the pyramid represent the top priority needs of physiological needs intertwined with safety. See Figure 4.8 for an image of Maslow’s Hierarchy of Needs. You may be asking yourself, “What about the ABCs – isn’t airway the most important?” The answer to that question is “it depends on the situation and the associated safety considerations.” Consider this scenario – you are driving home after a lovely picnic in the country and come across a fiery car crash. As you approach the car, you see that the passenger is not breathing. Using Maslow’s Hierarchy of Needs to prioritize your actions, you remove the passenger from the car first due to safety even though he is not breathing. After ensuring safety and calling for help, you follow the steps to perform cardiopulmonary resuscitation (CPR) to establish circulation, airway, and breathing until help arrives.
In addition to using Maslow's Hierarchy of Needs and the ABCs of airway, breathing, and circulation, the nurse also considers if the patient's condition is an acute or chronic problem. Acute, uncompensated conditions generally require priority interventions over chronic conditions. Additionally, actual problems generally receive priority over potential problems, but risk problems sometimes receive priority depending on the patient vulnerability and risk factors.

**Example.** Refer to Scenario C in the “Assessment” section of this chapter. Four types of nursing diagnoses were identified for Ms. J.: *Fluid Volume Excess, Enhanced Readiness for Health Promotion, Risk for Falls,* and *Risk for Frail Elderly Syndrome.* The top priority diagnosis is *Fluid Volume Excess* because it affects the physiological needs of breathing, homeostasis, and excretion. However, the *Risk for Falls* diagnosis comes in a close second because of safety implications and potential injury that could occur if the patient fell.

